

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/10/2011
FORM APPROVED
OMB NO. 0938-0391

#2 acceptable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/10/2011
NAME OF PROVIDER OR SUPPLIER JEFFERSON COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 914 INDUSTRIAL PARK RD DANDRIDGE, TN 37725		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure safety devices were in place for two residents (#1, #2) with a history of falls of five residents reviewed.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on March 3, 2011, with diagnoses including Hypertension, Arthritis, Diabetes Mellitus, Diabetic Neuropathy, Senile Dementia, History of Falls and Alzheimer's Disease. Review of a hospital History and Physical dated February 1, 2011, revealed, "...started falling and now can no longer get around the house on...own...previously used a walker, but has had several recent falls...increasing weakness...needs assistance with ambulation...family would also like...go to skilled nursing care for rehabilitation in light of...inability to ambulate..." Medical record review of the admission nursing assessment dated March 3, 2011, revealed the resident was alert and oriented to person and place.</p> <p>Medical record review of admission physician's orders dated March 3, 2011, revealed,</p>	F 323	<p>Safety devices were in place for residents #1 and #2 on 03/10/11.</p> <p>On 03/10/11, the R.N. Unit Managers made compliance rounds to ensure that all residents who had been assessed for safety devices had them in place.</p> <p>All residents are assessed upon admission for safety devices by the R.N. Unit Manager or shift supervisor. The information is entered into the facility's electronic medical record (EMR) by the R.N. Unit Manager or shift supervisor. As a change in condition occurs with a resident resulting in a safety device change, the R.N. Unit Manager or shift supervisor implements the safety device change and updates the information in the facility's EMR. Safety device information is available to all nursing staff including the C.N.A.'s on the wall mounted kiosk where ADL information is entered. Nursing staff including C.N.A.'s are trained regarding the use of the EMR and wall mounted kiosk during orientation and on an as needed basis.</p> <p>A check of safety devices is made on each shift by the C.N.A.'s. This is also documented on the wall mounted kiosks. Compliance is monitored by rounds being made each shift by the R.N. Unit Manager or shift supervisor. If noncompliance is noted, it is addressed immediately with the C.N.A.</p>	03/21/2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Roger L. Myman

TITLE

Administrator

(X6) DATE

3/18/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	<p>Continued From page 1</p> <p>"...Ambulatory With Assistance With Cane/walker High Fall Risk..."</p> <p>Medical record review of the initial care plan dated March 3, 2011, revealed, "...Potential for falls...Attendant alarm for new admit...safety precautions..."</p> <p>Medical record review of the fall risk assessment dated March 3, 2011, revealed the resident was at high risk for falls with a total score of "19" (9 or greater=High risk).</p> <p>Observation on March 9, 2011, at 8:25 a.m., revealed the resident sitting on the side of the bed complaining of abdominal pain and the need for a bowel movement. Observation revealed the case of a clip alarm was mounted on the side rail, and the alarm was not attached to the resident.</p> <p>Observation and interview on March 9, 2011, at 8:28 a.m., with Certified Nursing Assistant (CNA) #1 confirmed the clip alarm was not attached to the resident.</p> <p>Interview on March 9, 2011, at 10:10 a.m., in the conference room, with the Director of Nursing (DON) confirmed the resident had a history of falls prior to admission to the facility; had been assessed at high risk for falls by the facility; and the resident had not been assessed as to the safety of discontinuing the personal alarm.</p> <p>Resident #2 was admitted to the facility on August 29, 2005, with diagnoses including Angina, Hypertension, Gastrointestinal Reflux Disease, Gout, Osteoporosis, Degenerative Joint Disease, Depression, Diabetes Mellitus and Back Pain.</p> <p>Medical record review of the Minimum Data Set</p>	F 323			

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F 323	<p>Continued From page 2</p> <p>dated February 24, 2011, revealed the resident had impaired decision-making skills; required two persons for bed mobility; was not ambulatory; and required extensive assistance with eating and bathing.</p> <p>Medical record review of a nurse's note dated February 11, 2011, revealed, "...nurse called to residents room...observed to be lying on...back on the floor beside...bed...replied...had hit...head and that...neck was hurting...CNA stated that as...turned resident in bed that resident began to slid off of bed. CNA states...went to opposite side of bed and assisted resident to the floor. CNA states that resident did not hit...head..." The resident was transferred to the hospital.</p> <p>Medical record review of a hospital x-ray report dated February 11, 2011, revealed, "...compression fracture deformity...L1 with probable acute appearance...Mild compression deformity...T12 is more age indeterminate..."</p> <p>Medical record review of the care plan dated February 24, 2011, revealed, "...LV1...Fracture...Attendant Alarm on in bed..."</p> <p>Observation on March 9, 2011, at 8:30 a.m., revealed the resident lying in bed with a neck pillow in place. Continued observation revealed a clip alarm was mounted on the side rail and revealed the clip alarm was not attached to the resident.</p> <p>Observation on March 9, 2011, at 8:35 a.m., with the Registered Nurse/Unit Manager revealed the resident lying in bed with the clip alarm attached.</p> <p>Interview on March 9, 2011, at 8:40 a.m., with</p>	F 323			

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F 323	Continued From page 3 CNA #1 confirmed CNA #1 entered the resident's room after the surveyor left the room; the clip alarm was not attached; and CNA #1 reattached the alarm to the resident. CNA #1 stated, "Because you had asked me earlier about an ...alarm, I saw (resident #2's) was not on and I reattached it ..." C/O #27599	F 323			